Administrative Code

Title 23: Medicaid
Part 215

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Rule 1.1: General

A. The Division of Medicaid covers home health services for a beneficiary that is:

1. Essentially homebound;

2. Under the care of a physician; and

3. In need of home health services on an intermittent basis.

B. The beneficiary's residence shall not include a hospital, skilled nursing facility, or a mental or criminal institution.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.2: Provider Enrollment Requirements

Home health providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Written confirmation from the IRS confirming your tax identification number and legal business name.

C. Copy of the Tie-In Notice. The EOMB is not acceptable.

D. Copy of License from the Mississippi State Board of Health, Health Facilities Licensure and Certification. If parent entity is an out of state facility with a servicing location in Mississippi, a copy of the respective State's license is required.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; 42 CFR § 484

Rule 1.3: Criteria for Coverage

A. The Division of Medicaid covers home health services for beneficiaries who are under the care of an attending physician when the services are prescribed by the beneficiary's attending physician.

1. The attending physician's order is part of a written Plan of Care.

2. The attending physician must review and recertify the written Plan of Care every sixty (60) days.

B. The Division of Medicaid covers home health agency services, like home nursing care services, home health aide services, and home physical therapy or speech therapy, on an intermittent basis when:

1. Documentation is present in the beneficiary's medical record which justifies that the services are medically necessary and reasonable for the treatment of the beneficiary's illness, injury, or condition; and

2. The beneficiary's medical condition, illness, or injury requires services that must be delivered at the beneficiary's place of residence rather than at an office, clinic, or other outpatient facility, according to one (1) or more of the following guidelines:

a) The beneficiary's travel to a physician's office, clinic, or other outpatient setting for the needed service would create a medical hardship for the patient due to the beneficiary's specific illness, injury, or disability.

1) The Division of Medicaid defines medical hardship as including, but not limited to:

i) A patient who requires ambulance transportation due to the severity of their medical condition.

ii) A patient in severe pain.

iii) A patient with bilateral upper extremity loss who is unable to open doors, use handrails or perform other activities, and needs help to leave his/her residence.

iv) A patient for whom leaving the home is likely to cause an exacerbation of his/her condition.

v) A patient who experiences shortness of breath that significantly hinders travel.

vi) A diabetic patient who is wheelchair bound due to bilateral lower extremity amputations and makes only infrequent trips from his residence due to medical complications of the amputations.

2) The Division of Medicaid defines conditions that in and of themselves are not considered hardship including, but not limited to:

i) The use portable oxygen.

ii) Walking with a limp.

iii) The use an assistive device such as a cane, walker, or wheelchair.

iv) A wheelchair-bound patient who regularly drives a specially equipped vehicle to travel outside of the home.

v) The need for routine transportation. Refer to Part 201, Chapter 2.

vi) The need for a child to be supervised by an adult when the child is outside the home.

b) The beneficiary's travel to a physician's office, clinic, or other outpatient setting for needed services is contraindicated by written documentation in the beneficiary's medical record of a fragile or unstable medical condition. The beneficiary's physician must document in writing that the beneficiary's condition is so fragile or unstable that the beneficiary's leaving their home for services is undesirable or detrimental to the beneficiary's health. The Division of Medicaid defines a fragile or unstable medical condition as including, but not limited to:

1) A newborn infant up to six (6) weeks of age who has acute care needs, or who is at medical risk of complications.

2) A beneficiary who has just had a major surgical procedure and has significant postoperative weakness and pain. Because of his/her condition, their physician has documented restriction(s) of the beneficiary to limited activities and allows only brief periods of time out of bed.

3) A beneficiary with severe arteriosclerotic or congestive heart disease who is ordered by his/her physician to avoid all stress and physical activity.

4) A beneficiary with a serious or immunocompromised medical condition whose physician has documented that protection from exposure to infections is medically necessary.

5) A beneficiary who has been released from the hospital less than forty-eight (48) to seventy-two (72) hours after major surgery.

c) Traveling to a physician's office, clinic, or other outpatient setting for a needed service would interfere with the effectiveness of the service as defined The Division of Medicaid including, but not limited to:

1) A beneficiary who needs a service repeated at intervals difficult to accomplish in a physician's office, clinic, or other outpatient setting.

2) A beneficiary who needs regular or unpredictable catheter changes.

3) A beneficiary who has a documented past failure to comply with visits to a physician's office, clinic, or other outpatient setting for the needed services, and has also suffered, or has a high probability of suffering, documented adverse health consequences as a result of their noncompliance, including frequent use of emergency room and hospital admissions. The beneficiary's non-compliance must be documented to be a direct result of their illness, injury, or disability including mental disorders. The Division of Medicaid defines situations meeting this criteria as including, but not limited to:

i) A beneficiary newly diagnosed with End Stage Renal Disease (ESRD) who has been prescribed a specialized diet with significant restrictions.

ii) A beneficiary who has an abdominal wound dehiscence.

iii) A beneficiary who requires use of assistance devices that have been specifically customized for the patient's home environment which requires reinforcement on the use of the assistive devices, including bath chairs and shower grab bars.

C. The place of residence for the purpose of determining home health services is the address at which the beneficiary lives.

1. The Division of Medicaid defines the place of residence as the beneficiary's:

a) Own private home or apartment;

b) Relative's home; or

c) A home for the aged or boarding home.

2. To qualify for home health benefits, the beneficiary cannot be a resident of an institution that meets the basic definition of a hospital or nursing facility.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.4: Covered/Non-Covered Services

A. The Division of Medicaid covers twenty-five (25) home health visits per state fiscal year, July 1-June 30.

1. The visits may be a combination of a skilled nurse and/or home health aide**.**

2. Home health aide visits will be allowed without the requirement for skilled care by a nurse.

B. Medicaid covers the cost of medical supplies reported in the medical supplies cost center of the Medicare cost report, which are directly identifiable supplies furnished to individual patients and for which a separate charge is made, in the payment for the visit.

C. Physical therapy and speech therapy visits are not covered through the home health program.

D. Medicaid does not cover Durable Medical Equipment (DME), orthotics, or prosthetics supplied through a home health agency.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.5: Certification Requirements

A. The Division of Medicaid requires the ordering physician have full responsibility for maintaining auditable records that verify services provided by the home health agency are medically necessary. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following for each beneficiary:

1. Copy of the initial certification;

2. Copy of all recertifications;

3. Copy of any new orders, medications, or other treatment changes;

4. Documentation of all examinations and evaluations which clearly indicate the medical necessity for ordering home health services and the need for continuation of those services;

5. Copy of the case conference report(s) covering all disciplines;

6. Copy of any lab, x-ray, or other diagnostic test results;

7. Copy of discharge summary to include all transfers and hospital stays; and

8. Documentation of all verbal communications between the home health agency and the physician.

B. It is the responsibility of the home health agency to supply the ordering physician with copies of reports or records as needed for the physician office files.

1. Practitioners must provide a statement of certification /recertification that shows the medical necessity for home health services, the type of services required, and the period of time home health services will be needed.

2. The Division of Medicaid requires that an individual requiring a level of care which would make them eligible for home health benefits be seen by the specializing physician

or the primary care physician at least once every sixty (60) days.

3. The practitioner must provide a written recertification statement indicating there is a continuing need for home health services and approximately how long services will be needed.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 42 CFR 424.22; 42 CFR 484

Rule 1.6: Documentation

The Division of Medicaid requires the home health agency to maintain auditable records that substantiates the services provided. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following on each beneficiary:

A. Physician referral;

B. Appropriate identifying information;

C. Name of the physician;

D. Original signed copy of the initial certification;

E. Original signed copy of all recertifications;

F. Original signed copy of any new orders, change in orders, medications, medical supplies or other treatment changes;

G. Original copy of case conference report(s) covering all disciplines;

H. Original copy of all lab results and other diagnostic test results;

I. Original copy of discharge summary to include transfers and hospital stays;

J. Documentation of all verbal communications between the home health agency and the physician; and

K. Signed copy of drug, dietary, treatment and activity orders including any new changes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR 484.48

Rule 1.7: Home Health Services Provided in Another State

A. The Division of Medicaid must pay for services furnished in another state to the same extent that it would pay for services furnished within the boundaries of Mississippi if the services are furnished to a beneficiary who is a resident of this state, and any of the following conditions are met:

1. Medical services are needed because of a medical emergency.

2. Medical services are needed and the beneficiary's health would be endangered if she/he were required to travel to her/his state of residence.

3. The Division of Medicaid determines, on the basis of medical advice, the needed medical services or necessary supplementary resources are more readily available in the other state.

4. It is general practice for beneficiaries in a particular locality to use resources in another state.

B. The Division of Medicaid requires the following guidelines for an out of state home health agency:

1. If the beneficiary has been a resident for more than thirty (30) days in the state where the home health agency operates, the beneficiary would be considered a resident of that state and the Mississippi Division of Medicaid would not reimburse for services provided, or

2. If the beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates, the Mississippi Division of Medicaid would reimburse for services.

C. Out-of-state providers are required to request a provider number and meet all home health agency requirements.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.52.

Rule 1.8: Dual Eligibles

Beneficiaries eligible for Medicare and Medicaid must not receive home health visits under both programs simultaneously. Refer to Part 200, Chapter 2, Rule 2.5.

A. If Medicare does not cover home health nurse visits, physical therapy visits, or speech therapy visits because skilled services are not being provided, the Division of Medicaid will not cover the services.

B. If Medicare does not cover home health aide visits because a skilled service is not being provided, the Division of Medicaid will cover medically necessary aide visits.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Reimbursement

A. The Division of Medicaid covers home health agency reimbursement for covered services based on reasonable cost which is determined in accordance with the Mississippi Medicaid Home Health Reimbursement Plan and Title XVIII, Medicare, principles of reimbursement, except when Medicare guidelines are contradictive to directives of the State Plan or Division of Medicaid. In such a situation, the State Plan or Division of Medicaid will prevail.

1. Medicaid cost reporting schedules must be included with the Medicare cost report to compute Medicaid reimbursement.

2. A schedule must be completed to reflect the lower of reasonable costs or customary charge provisions as they apply to Medicaid.

3. In addition to the lower of costs or charge limitations, reimbursement for home health services is limited to and cannot exceed the prevailing costs of providing nursing facility services in the Mississippi Medical Assistance (Medicaid) Program.

B. The Division of Medicaid will reimburse for the initial assessment visits and supervisory visits for skilled services, either Home health Skilled (HHSK), Home Health Physical Therapy (HHPT), and/or Home Health Speech Therapy (HHST), and aide services when the following criteria is met:

1. If a beneficiary is assessed for skilled services, without a skilled service performed during the initial assessment visit and is not admitted to the home health program, the initial assessment visit is not approved and must be claimed as an administrative cost.

2. If a beneficiary is assessed for skilled services, with a skilled service performed during the initial assessment visit and is admitted to the home health program for continuation of skilled visits, the initial assessment visit is not an administrative cost and can be billed.

3. If a beneficiary is assessed for skilled services with a skilled service performed during the initial assessment visit only, the home health agency must elect either to:

   a) Claim this as an administrative cost; or

   b) Admit to and discharge the beneficiary from the home health program for this one (1) visit. This is not an administrative cost and can be billed.

4. If a beneficiary is assessed for home health aide services only, without a skilled service performed during the initial assessment visit and is not admitted to the home health program, the initial assessment visit is not approved and must be claimed as an administrative cost.

5. If the beneficiary is assessed for home health aide services only and is admitted to the home health program and a skilled service is performed during the initial assessment visit, the home health agency must elect either to:

a) Claim the assessment as an administrative cost; or

b) Bill the initial assessment visit as a skilled service.

C. Initial assessment visits must be performed by a registered nurse.

D. If the beneficiary is receiving home health aide services only, a supervisory visit must be made every sixty (60) days by a registered nurse while the home health aide is providing patient care. Supervisory visits are administrative costs and are not directly reimbursable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 484, Subpart E

Rule 1.10: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121